COUNTRY RESEARCH SERIES | NUMBER 12 | APRIL 2003

Willingness to Pay Increased Prices for Reproductive Health Products and Services in Ghana

William Winfrey

COMMERCIAL MARKET STRATEGIES
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

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COMMERCIAL MARKET STRATEGIES

Commercial Market Strategies (CMS) is the flagship private-sector project of USAID's Office of Population and Reproductive Health. The CMS project, in partnership with the private sector, works to improve health by increasing the use of quality family planning and other health products and services.

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THIS PUBLICATION FINANCED BY USAID

This publication was made possible through support provided by the Bureau of Global Health, Office of Population and Reproductive Health, United States Agency for International Development (USAID) under the terms of Contract No. HRN-C-00-98-00039-00. The views and opinions of the author expressed herein do not necessarily state or reflect those of USAID or the US Government.

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ACKNOWLEDGMENTS

Gerry Vandyck at Research International in Ghana supervised the collection of the data for this report. The author also wishes to acknowledge the many people who contributed to the development and publication of this report: Sohail Agha, Asma Balal, Ruth Berg, Patricia Mengench, and Francis Okello for their assistance with the conceptualization of the study and review of the report; Rudolph Chandler and Susan Mitchell for their direction; Patricia Miller and Jayson Hait for their editing; and Christine Prefontaine for the production of this report.

ABSTRACT

Limited government and donor resources, as well as the need to serve ever-increasing reproductive health (RH) needs, dictate that the partners for reproductive health in Ghana — the Ministry of Health, Planned Parenthood Association of Ghana, and the Ghana Social Marketing Foundation — find new ways to increase sustainability and expand financial resources. One way to increase sustainability is to improve cost recovery by increasing prices for RH products and services. This report is based on data collected from client intercept surveys to determine the willingness to pay more for RH products and services among men and women.

For almost all products, more than 75 percent of clients say they are willing to pay at least 50 percent more than they are currently paying. The report also addresses the question of what would happen if prices increased too much for clients to be able to afford their current family planning product. The results indicate that fewer than 10 percent of current clients would stop using family planning. The majority said they would seek a cheaper brand at their current source of supply or try to find a cheaper source for the same brand. The author concludes that there is adequate room for marketers and policymakers to increase prices for all classes of family planning products in Ghana.

KEY WORDS

Willingness to pay, family planning, health insurance, private sector, social marketing, Ghana, USAID, Commercial Market Strategies.

RECOMMENDED CITATION

Winfrey, W. 2002. *Willingness to Pay Increased Prices for Reproductive Health Services in Ghana.* Washington DC: USAID/Commercial Market Strategies Project.

Willingness to Pay Increased Prices for Reproductive Health Products and Services in Ghana

COUNTRY RESEARCH SERIES NUMBER 12
April 2003

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1 Introduction

INTRODUCTION

Limited government and donor resources, as well as the need to serve ever-increasing reproductive health (RH) needs, dictate that the partners for reproductive health in Ghana — the Ministry of Health (MOH), Planned Parenthood Association of Ghana (PPAG), and the Ghana Social Marketing Foundation International (GSMF) — find new ways to increase sustainability and expand their financial resource bases. Many ways to improve sustainability are being explored, including the following:

- improved cost recovery
- improved efficiency of service delivery
- reallocation of financial resources within institutions providing health care
- better mobilization of partner institutions

This report provides information on the feasibility of improved cost recovery through increased prices for RH products and services. In Ghana, nearly all RH products and services are subsidized with government, donor, or non-governmental organization funds. Increased prices for these products and services will decrease the level of subsidies needed, which will allow the partner institutions to reallocate resources to the population segments that are in the greatest need. Additionally, decreased reliance on subsidies is insurance against future program failure if government or donor resources are ever removed from the program, a primary concern of the Contraceptive Security Initiative of the United Nations Population Fund and the United States Agency for International Development.

This report is based on data collected from two client intercept surveys of men and women who purchased RH products, including male and female condoms, intrauterine devices (IUDs), implants, injectables, pills, and vaginal foaming tablets (VFTs) at outlets in Ghana. One survey was conducted at the exits of pharmacies and chemical shops and involved only RH products. The second survey was conducted at the exits of MOH and PPAG facilities and involved RH products and services.

Following a short discussion about the survey methods, the report presents an analysis of willingness-to-pay data for clients of pharmacies and chemical shops by three contraceptive categories: condoms, hormonal family planning products, and family planning methods controlled by women (female condoms and VFTs). Each of the three subsections presents data on the socioeconomic characteristics of the clients and their willingness to pay more for the products they purchased. Next, findings are presented on willingness to pay for RH products and services in clinical and hospital settings. Following this section, the report addresses the question of what purchasers of RH products and services would do if prices increase beyond what they are willing to pay. Finally, the major findings of the report are summarized.

2 Research Methods

RESEARCH METHODS

Research International (RI) fielded a client intercept survey of 2,670 purchasers of RH products. Purchasers were intercepted at a representative sample of 147 randomly selected outlets located in 10 regions of Ghana. Outlets sampled included 105 chemical shops (1,845 clients), 23 pharmacies (504 clients), 10 MOH maternal and child health clinics (197 clients), 5 MOH hospitals (63 clients), and 4 PPAG clinics (61 clients). Eighty interviewers and 26 supervisors were stationed at the selected facilities over a period of 14 days to gather data from clients who visited the facilities. Two interviewers, one male and one female, were placed at each outlet to ensure that the gender of the respondent was the same as that of the interviewer.[1]

The Commercial Market Strategies (CMS) project and RI employed a three-step survey technique that has been widely used in health policy development and the environmental field.

1. Typically, the surveyor carefully describes the product or service about which willingness-to-pay information is desired. In this survey, however, a thorough description of the product was not necessary because the client had just purchased it.

2. The surveyor asks the interviewee if he or she is willing to pay a suggested price for the service or product. If the respondent says "yes," the surveyor asks him/her whether he/she would pay a higher stated price. If the respondent says "no" to the first question, the surveyor asks him/her whether he/she would pay a lower suggested price. The price points in this survey correspond to prices 25 percent, 50 percent, and 100 percent higher than the price the respondent reported paying for the service or product (see the Appendix for the exact questions).

3. Typically, if the interviewee says "no" to all of the price points posed, the surveyor will ask why he/she is unwilling to pay. In this survey, however, a variation on this question was posed to all interviewees: "If the price of [family planning product] at this establishment went up more than you were willing to pay, what would you do instead?"

The MOH, PPAG, and GSMF also are interested in the differential impact of price increases on different socioeconomic groups. Standard-of-living measures for socioeconomic groups are presented as a means of analyzing ability to pay. We assume that clients in higher socioeconomic groups have a greater ability to pay. In the analysis, classification of consumers' socioeconomic status into a Standard of Living Index (SLI) was based on two measures: reported monthly income and an aggregate index of household assets reported by the interviewee. The aggregate index of household assets is based on a factor analysis technique developed by Macro International and the World Bank. The index is used to rank people from lowest to highest and assign them to one of five quintiles. The quintile rankings are referenced to the entire population of Ghana, so SLI characterizations apply to all households.[2] Our sample is skewed to the wealthier segments of the population since it is based on people buying family planning products.

A NOTE ON SAMPLE SIZE

Statistical confidence in results increases or decreases depending on the number of purchasers interviewed and the percentage of those purchasers who responded affirmatively to a particular question. In this study, there were few purchasers for some of the products and services. When there are few purchasers, the margin of error or confidence interval is large. The confidence interval also is associated with the percentage responding affirmatively to a question. The closer the percentage is to 50 percent, the wider the confidence interval. Table 1 summarizes approximations of the confidence intervals.

In Section 3, the results of a chi-square test of the differences across the brands or SLIs are presented for each of the tables drawn from the pharmacy and chemical shop surveys. Because of the small sample sizes and lack of real comparability across the columns of the hospital and clinic survey results, chi-square tests are not presented in Section 4.

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1 The Appendix details the distribution of the interviews.

2 The index cut-off points as reported in Gwatkin et al. (2000) were used to create quintiles based on the entire population of households in Ghana. For details, see Gwatkin D, S Rutstein, K Johnson, R Pande, and A Wagstaff. 2000. *Socioeconomic Differences in Health, Nutrition, and Population in Ghana*. Washington DC: World Bank HNP/Poverty Thematic Group.

A NOTE ON BRAND NAMES

The original objective of this survey was to investigate willingness to pay increased prices for GSMF products. The focus was later extended to cover MOH and PPAG services. Therefore, the survey instruments were designed to capture the names of GSMF products. All non-GSMF brands were coded under "Other brand." In cases where the purchaser did not specify the brand name, the results are presented generically as condoms, oral contraceptives, injectables, and female condoms. In the case of condoms purchased at pharmacies or chemical shops, we speculate that the "Other brand" condoms are fully commercial condoms because their prices are relatively high (see Table 3). In the case of condoms purchased at MOH and PPAG facilities, we speculate that the "Other brand" condoms are the unbranded condoms distributed through public channels.

Table 1. Confidence intervals for various sample sizes and percentages of sample responding "yes"*

Number of observations	50%	40% or 60%	30% or 70%	20% or 80%
15	+/– 25.3%	+/– 24.8%	+/– 23.2%	+/– 20.2%
20	+/– 21.9%	+/– 21.5%	+/– 20.1%	+/– 17.5%
25	+/– 19.6%	+/– 19.2%	+/– 17.9%	+/– 15.7%
50	+/– 13.8%	+/– 13.6%	+/– 12.7%	+/– 11.1%
100	+/– 9.8%	+/– 9.6%	+/– 8.9%	+/– 7.8%
250	+/– 6.1%	+/– 6.0%	+/– 5.6%	+/– 4.9%
500	+/– 4.3%	+/– 4.2%	+/– 3.9%	+/– 3.4%

* *Table based on calculations made by confidence interval calculator at www.surveysystem.com/sscalc.htm, using a confidence level of 95 percent and a large population size.*

3 Willingness to Pay at Pharmacies and Chemical Shops

WILLINGNESS TO PAY AT PHARMACIES AND CHEMICAL SHOPS

PURCHASERS OF CONDOMS AT PHARMACIES AND CHEMICAL SHOPS

DEMOGRAPHICS OF CONDOM PURCHASERS

Table 2 presents the characteristics of the men and women who purchased condoms at pharmacies and chemical shops. The condom brands are arranged, left to right, from most expensive to least expensive. *Champion* and *Panther* condoms are cheaper social marketing brands targeted to low-income users. "Other brand" (because the condoms are unidentified) appears at the far right, but represents fully priced commercial condoms (see Table 3).

Men are overwhelmingly the purchasers of condoms across brands. Condom price paid is correlated to income, socioeconomic status, education, and urban or rural residency. Purchasers of the least expensive brands are more likely to live in rural areas, have low reported income, have a low socioeconomic status (as reported by SLI), and be relatively poorly educated. *Champion* condoms are sold to a relatively high percentage of young men.

Overall, the interviewed condom purchasers are well-off relative to the population of Ghana. For all but *Champion* condom buyers, more than three-quarters of the purchasers are among the Highest 20 percent of the population. Almost none of the purchasers of condoms fell into the Lowest 60 percent of the population, and relatively few were in the Upper-Middle 20 percent.

WILLINGNESS TO PAY MORE FOR CONDOMS AT PHARMACIES AND CHEMICAL SHOPS

Table 3 presents the results of the willingness-to-pay questions posed to condom purchasers at pharmacies and chemical shops. The first two rows present the median price paid for condoms by the piece and pack, respectively. (*Champion* condoms are sold individually or in strips of four; the price per pack indicates a strip of four.) The median price paid for the "Other brand" is higher than that for the identified brands, which implies that most of these condoms are fully commercial brands.

For each brand of condoms, there is a core of about 10 percent to 15 percent of purchasers who are not willing to pay anything more than they are currently paying. However, 85 percent to 90 percent of all condom purchasers are willing to pay at least 25 percent more than they are currently paying. Nearly 75 percent of purchasers of all condom brands are willing to pay at least 50 percent more than they are currently paying. More than 60 percent of *Champion* condom purchasers are willing to pay twice as much as they are currently paying. Only about 40 percent of the buyers of *Protector*, the most expensive identified brand, are willing to pay double the current price. Almost half of the "Other brand" purchasers are willing to pay double the current price.

Table 4 presents willingness-to-pay information by the standard of living of the purchasers, which is a proxy for ability to pay in this study. Empty cells in the table indicate that there were fewer than 10 people who purchased the product in the SLI group.

Almost all of the *Protector* purchasers are in the highest SLI group. An increase in prices for *Protector* would not cause a major shift in the economic profile of purchasers because they are already relatively wealthy. *Panther* and *Champion* condom purchasers do not show a clear pattern with respect to the SLI categories. Between 80 percent and 85 percent of *Champion* purchasers in each SLI group are willing to pay at least an additional 50 percent more.

PURCHASERS OF HORMONAL FAMILY PLANNING PRODUCTS AT PHARMACIES AND CHEMICAL SHOPS

DEMOGRAPHICS OF HORMONAL FAMILY PLANNING PURCHASERS

Table 5 presents the characteristics of purchasers of hormonal family planning products at pharmacies and chemical shops. The number of purchasers of hormonal family planning products is much smaller than the number of condom purchasers. *Secure*, a GSMF oral contraceptive, is the most frequently purchased hormonal product in our sample, with

Table 2. Characteristics of condom purchasers by gender, location, age, income, education, and SLI (percent)

	Protector	*Panther*	*Champion*	Other brand
Gender				
Male	85.0	85.8	83.3	88.2
Female	15.0	14.2	16.7	11.8
Total	100	100	100	100
Location				
Urban	81.7	72.5	56.2	69.8
Rural	18.3	27.5	43.8	30.2
Total	100	100	100	100
Age				
15–24	29.2	26.9	42.7	32.2
25–34	56.7	53.5	44.1	46.3
35 plus	14.2	19.6	13.2	21.6
Total	100	100	100	100
Reported monthly income (in thousands)				
400 or less	15.0	18.6	27.2	19.8
401–1,000	37.2	42.0	44.4	36.7
More than 1,000	47.8	39.4	28.4	43.5
Total	100	100	100	100
Education				
No school or primary only	11.7	13.9	15.8	11.0
Some or completed junior secondary	8.3	14.9	24.1	19.2
Some or completed secondary	40.8	37.3	38.4	37.3
Post-secondary education	39.2	33.9	21.7	32.5
Total	100	100	100	100
Asset-based SLI (standardized compared to entire population of Ghana)				
Highest 20%	91.7	76.9	69.5	83.9
Upper-Middle 20%	7.5	13.3	21.3	13.3
Lowest 60%	0.8	9.8	9.2	2.7
Total	100	100	100	100
Number of observations	**120**	**316**	**771**	**255**

Table 3. Prices paid and willingness to pay more among condom purchasers (percent)*

	Protector	*Panther*	*Champion*	Other brand
Prices paid				
Median price paid (cedis) — piece	300	250	200	2,000
Median price paid (cedis) — pack	1,500	1,000	1,000	2,500
Willingness to pay more				
Not willing to pay more	14.2	10.1	9.6	15.7
Willing to pay 25% more	85.8	89.9	90.4	84.3
Willing to pay 50% more	73.3	79.1	83.8	74.1
Willing to pay 100% more	40.0	49.4	62.1	49.4
Number of observations	**120**	**316**	**771**	**255**

* *Differences across the condom brands of the percentage of customers willing to pay at least 25 percent more are significant at the 5 percent level, according to a chi-square test.*

Table 4. Willingness to pay more among condom purchasers by SLI (percent)

	Lowest 60%	Upper-Middle 20%	Highest 20%	All current purchasers
Protector				
Not willing to pay more	—	—	14.5	14.2
Willing to pay 25% more	—	—	85.5	85.8
Willing to pay 50% more	—	—	72.7	73.3
Willing to pay 100% more	—	—	40.0	40.0
Number of observations	—	—	**110**	**120**
Panther				
Not willing to pay more	6.5	9.5	10.7	10.1
Willing to pay 25% more	93.5	90.5	89.3	89.9
Willing to pay 50% more	74.2	76.2	80.3	79.1
Willing to pay 100% more	32.3	47.6	51.9	49.4
Number of observations*	**31**	**42**	**243**	**316**
Champion				
Not willing to pay more	7	11	9.5	9.6
Willing to pay 25% more	93.0	89.0	90.5	90.4
Willing to pay 50% more	83.1	83.5	84	83.8
Willing to pay 100% more	70.4	58.5	62.1	62.1
Number of observations*	**71**	**164**	**535**	**770**
Male condom (not specified)				
Not willing to pay more	—	14.7	15.9	15.7
Willing to pay 25% more	—	85.3	84.1	84.3
Willing to pay 50% more	—	82.3	72.9	74.1
Willing to pay 100% more	—	52.9	49.1	49.4
Number of observations*	—	**34**	**214**	**255**

* *Differences across the SLI groups of the percentage of customers willing to pay at least 25 percent more are not significant at the 10 percent level, according to a chi-square test.*

Table 5. Characteristics of hormonal family planning method purchasers by gender, location, age, income, education, and SLI (percent)

	Oral contraceptives		
	Secure	**Other oral pill**	**Injectables**
Gender			
Male	5.1	3.9	2.9
Female	94.9	96.1	97.1
Total	100	100	100
Location			
Urban	65.2	56.6	71.4
Rural	34.8	43.4	28.6
Total	100	100	100
Age			
15–24	31.2	44.7	17.2
25–34	52.7	36.8	65.7
35 plus	16.1	18.4	17.1
Total	100	100	100
Reported monthly income (in thousands)			
400 or less	23.0	42.1	12.9
401–1,000	44.6	31.6	50.1
More than 1,000	32.4	26.3	37.0
Total	100	100	100
Education			
No school or primary only	28.0	31.6	37.2
Some or completed junior secondary	20.6	27.6	11.4
Some or completed secondary	29.9	26.3	20.0
Post-secondary education	21.4	14.5	31.4
Total	100	100	100
Asset-based SLI (standardized compared to entire population of Ghana)			
Highest 20%	70.7	76.3	68.6
Upper-Middle 20%	19.1	19.7	20.0
Lowest 60%	10.2	3.9	11.4
Total	100	100	100
Number of observations	**471**	**76**	**35**

471 buyers. Only 35 of the women exiting the pharmacies and chemical shops purchased injectables (including 20 who purchased *Famplan*). Almost all of the hormonal purchasers were women, presumably the women who would be using the products. Once again, the purchasers were wealthy relative to the general population in Ghana.

WILLINGNESS TO PAY MORE FOR HORMONAL FAMILY PLANNING PRODUCTS

The first row of Table 6 present the median price paid for hormonal contraceptives. As with condoms, about 10 percent to 15 percent of purchasers are unwilling to pay anything more than they are currently paying for their product. A total of 85 percent to 90 percent of oral contraceptive and injectable purchasers are willing to pay at least 25 percent more than they are currently paying. In fact, for both of these methods, more than 80 percent of consumers are willing to pay at least 50 percent more. More than 50 percent of oral contraceptive purchasers are willing to pay double the price they are now paying.

Table 7 shows willingness to pay more for hormonal methods by SLI. The empty cells indicate that there were fewer than 10 purchasers of the product within the SLI group. There is a clear trend toward an increased willingness to pay more for the *Secure* brand on the part of the wealthier purchasers. Therefore, a price increase for *Secure* could be expected to change the profile of *Secure* users toward wealthier quintiles. For the unspecified oral pill, willingness to pay more is about the same across each of the quintiles, so a change in the price shouldn't change the profile of purchasers. Virtually all of the injectable purchasers, including purchasers of *Famplan*, were in the wealthiest SLI group, so a price increase also shouldn't shift the SLI profile.

PURCHASERS OF FEMALE CONDOMS AND VFTS AT PHARMACIES AND CHEMICAL SHOPS

DEMOGRAPHICS OF FEMALE CONDOM AND VFT PURCHASERS

The purchasers of female condoms and VFTs were primarily women (see Table 8). As with the other products analyzed in this report, most of the purchasers interviewed were located in urban areas. However, the percentage of urban residents was not overwhelming and was similar to that of purchasers of *Champion* condoms, the least expensive condom brand. The purchasers of these methods also are concentrated in the upper-income groups and the Highest SLI quintile.

Table 6. Prices paid and willingness to pay more among purchasers of hormonal family planning methods (percent)

	Oral contraceptives		
	Secure	**Other oral pill**	**Injectables**
Median price paid (cedis) — piece	1,500	1,000	2,500
Not willing to pay more	9.6	10.5	11.9
Willing to pay 25% more	90.4	89.5	88.1
Willing to pay 50% more	81.6	80.3	82.1
Willing to pay 100% more	51.2	56.6	50.7
Number of observations*	**471**	**76**	**35**

* *Differences across hormonal contraceptives of the percentage of customers willing to pay at least 25 percent more are not significant at the 10 percent level, according to a chi-square test.*

Table 7. Willingness to pay more among purchasers of hormonal family planning methods by SLI (percent)

	Lowest 60%	Upper-Middle 20%	Highest 20%	All current purchasers
Secure				
Not willing to pay more	22.9	17.8	5.4	9.6
Willing to pay 25% more	77.1	82.2	94.6	90.4
Willing to pay 50% more	60.4	72.2	87.1	81.6
Willing to pay 100% more	25.0	37.8	58.6	51.2
Number of observations*	**48**	**90**	**333**	**471**
Other oral pill				
Not willing to pay more	—	13.3	10.3	10.5
Willing to pay 25% more	—	86.7	89.7	89.5
Willing to pay 50% more	—	80	79.3	80.3
Willing to pay 100% more	—	60	55.2	56.6
Number of observations**	—	**15**	**58**	**76**
Famplan				
Not willing to pay more	—	—	8.4	10
Willing to pay 25% more	—	—	91.6	90
Willing to pay 50% more	—	—	83.4	85
Willing to pay 100% more	—	—	62.5	65
Number of observations	—	—	**16**	**20**
Injectables				
Not willing to pay more	—	—	—	13.3
Willing to pay 25% more	—	—	—	86.7
Willing to pay 50% more	—	—	—	80
Willing to pay 100% more	—	—	—	40
Number of observations	—	—	—	**15**

* *Differences across the SLI groups of the percentage of customers willing to pay at least 25 percent more are significant at the 1 percent level, according to a chi-square test.*

** *Differences across the SLI groups of the percentage of customers willing to pay at least 25 percent more are not significant at the 10 percent level, according to a chi-square test.*

Table 8. Characteristics of female condom and VFT purchasers by gender, location, age, income, education, and SLI (percent)

	Kamal (VFT)	Female condom
Gender		
Male	16.1	7.8
Female	83.9	92.2
Total	100	100
Location		
Urban	55.9	59.1
Rural	44.1	40.9
Total	100	100
Age		
15–24	35.7	44.2
25–34	49.7	43.5
35 plus	14.7	12.3
Total	100	100
Reported monthly income (in thousands)		
400 or less	27.3	32.7
401–1,000	47.5	39.3
More than 1,000	25.2	28.0
Total	100	100
Education		
No school or primary only	19.6	26.6
Some or completed junior secondary	25.2	19.5
Some or completed secondary	33.6	33.8
Post-secondary education	21.7	20.1
Total	100	100
Asset-based SLI (standardized compared to entire population of Ghana)		
Highest 20%	74.1	67.5
Upper-Middle 20%	20.3	21.4
Lowest 60%	5.6	11.0
Total	100	100
Number of observations	**143**	**154**

WILLINGNESS TO PAY MORE FOR FEMALE-CONTROLLED FAMILY PLANNING METHODS

The profile of willingness to pay more for female-controlled family planning methods is similar to other methods (see Table 9). About 8 percent to 15 percent of purchasers are unwilling to pay any more than they currently are. Seventy-seven percent to 82 percent are willing to pay 50 percent more. And, finally, more than half are willing to pay twice as much as they currently are paying.

Table 10 shows willingness to pay more for female-controlled family planning methods by SLI. The empty cells indicate that there were fewer than 10 purchasers of the product within the SLI group. For *Kamal* (VFT), there is a noticeable difference between the Upper-Middle 20 percent and the Highest 20 percent SLI groups in terms of the percentage willing to pay twice as much for the product. More than 60 percent of the Highest SLI users are willing to pay 100 percent more, while just fewer than 45 percent of the Upper-Middle SLI users are willing to pay 100 percent more. If there were a very large price increase for *Kamal*, there would likely be a shift in the user profile toward wealthier clients. For the female condom, the two lower SLI groups are much less willing to pay more for the product. Based on this finding, the profile of female condom users could be expected to shift toward wealthier clients with even a modest price increase.

Table 9. Prices paid and willingness to pay more among purchasers of female-controlled family planning methods (percent)

	Kamal (VFT)	Female condom
Median price paid (cedis) — piece	1,500	500
Not willing to pay more	8.4	14.9
Willing to pay 25% more	91.6	85.1
Willing to pay 50% more	81.8	77.2
Willing to pay 100% more	55.9	55.8
Number of observations*	**143**	**154**

* *Differences across the female-controlled methods of the percentage of customers willing to pay at least 25 percent more are significant at the 10 percent level, according to a chi-square test.*

Table 10. Willingness to pay more among purchasers of female-controlled family planning methods by SLI (percent)

	Lowest 60%	Upper-Middle 20%	Highest 20%	All current purchasers
***Kamal* (VFT)**				
Not willing to pay more	—	13.8	5.7	8.4
Willing to pay 25% more	—	86.2	94.3	91.6
Willing to pay 50% more	—	75.8	84	81.8
Willing to pay 100% more	—	44.8	60.4	55.9
Number of observations*	—	**29**	**106**	**143**
Female condom (not specified)				
Not willing to pay more	23.5	24.2	10.6	14.9
Willing to pay 25% more	76.5	75.8	89.4	85.1
Willing to pay 50% more	70.5	69.7	80.8	77.2
Willing to pay 100% more	52.9	48.5	58.7	55.8
Number of observations*	**17**	**33**	**104**	**154**

* *Differences across the SLI groups of the percentage of customers willing to pay at least 25 percent more are significant at the 10 percent level, according to a chi-square test.*

4 Willingness to Pay at MOH and PPAG Facilities

WILLINGNESS TO PAY AT MOH AND PPAG FACILITIES

Unlike the clients of pharmacies and chemical shops, clients of MOH and PPAG facilities cannot be classified solely on the basis of the family planning method or brand they received because these facilities provide additional services, such as examinations, and method-specific services, such as injection of injectables and insertion or removal of IUDs and implants.

A total of 321 MOH and PPAG clients were interviewed. All family planning clients leaving randomly selected clinics or hospitals were interviewed; the distribution of services is determined by the flow of clients only — we made no attempt to reach certain goals for any service type. As a result, some services do not have a large number of observations, and the small sample size may affect results. A common rule of thumb used in social sciences is that a group of observations should not be analyzed unless at least 25 cases exist; therefore, some aspects of our analysis are dictated by the distribution of services observed in the sample. The small number of family planning clients interviewed means that our level of confidence for any of the results in this section is low, relative to the results in the previous section.

Table 11 shows the breakdown of products received at MOH/PPAG facilities. The results are presented as frequencies to illustrate which products have enough respondents to offer the potential for analysis. In the first column, products received without a consultation or examination, *Champion* condoms and male condoms are viable groups for willingness-to-pay analyses. In the second column, products received with a consultation or examination, injectables and oral pills are viable groups for willingness-to-pay analyses.

Given the small number of respondents for many methods and services, the analyses of MOH and PPAG clients are limited to the following:

- comparison of willingness to pay more for IUD and *Norplant* services (combined),[3] oral contraceptives (total), female condoms and VFTs (total), condoms (total), and injectables (total)
- comparison of willingness to pay more for condoms when a consultation or service was received versus when a consultation or service was not received
- comparison of willingness to pay more for *Panther*, *Champion*, and condoms where the brand was not specified.

Table 12 presents the characteristics of family planning clients interviewed at PPAG and MOH facilities. (The profiles for clinical methods and female-controlled methods are based on relatively few clients and should be interpreted with caution.) Compared to the *Champion* condom purchasers at the chemical shops and pharmacies (see Table 2), the condom purchasers at the MOH/PPAG facilities are somewhat older, more rural, less educated, and less affluent. Compared to injectable purchasers at chemical shops and pharmacies (see Table 5), the injectable clients at the MOH/PPAG facilities are younger, more rural, less educated, and poorer. Compared to the purchasers of the oral contraceptive *Secure* at chemical shops and pharmacies (see Table 5), the oral contraceptive clients at MOH/PPAG facilities have about the same age distribution, but are much more likely to live in a rural area, be less educated, and poorer.

Table 13 presents the expressed willingness to pay more for various family planning methods at health care facilities.[4] More than 80 percent of the purchasers of each of the methods are willing to pay at least 50 percent more than they are currently paying. More than 70 percent of injectable, pill, and female-controlled family planning method purchasers are willing to pay double what they currently pay, and nearly 70 percent of the clinical method purchasers are willing to pay double. In general, purchasers of family planning methods that require clinical intervention are more willing to pay twice the price they currently pay than users of condoms. It appears that willingness to pay more for family planning products

3 We include this group of services even though the number of observations falls short of the usual statistical standard of 25 cases because they are a very distinct set of services relative to the other, more widely sold, resupply methods such as pills, condoms, VFTs, and injectables.

4 For this table and all that follow, chi-square tests of the differences across methods or services are not presented because the services are not sufficiently comparable. Prices paid are not presented because of the great variability within each category of service and the small sample sizes.

Table 11. Frequencies of products obtained at MOH and PPAG facilities

	Without consultation or examination	With consultation or examination	Total
IUD insertion	—*	8	8
IUD removal	—*	3	3
Norplant insertion	—*	1	1
Norplant removal	—*	4	4
Subtotal of clinical methods	—	16	16
Champion	38**	7	45**
Panther	22	3	25**
Protector	2	—	2
Male condom	40**	16	56**
Subtotal of condoms	102	26	128
Famplan	—	12	12
Injectables	19	61**	80**
Subtotal of injectables	19	73	92
Secure	6	8	14
Other oral pill	12	29**	41**
Subtotal of oral contraceptives	18	37	54
Female condom	6	8	14
Kamal	3	5	8
Contraceptrol	1	1	2
Neo-sampoon or jelly or cream tube	—	1	1
Subtotal of female-controlled methods	10	15	25
Emergency contraceptive pill	1	—	1
Not specified	1	3	4
Total	**151**	**170**	**321**

* *Indicates that the service requires clinical intervention.*

** *Indicates that there are sufficient observations for analysis.*

Table 12. Characteristics of MOH and PPAG clients by gender, location, age, income, education, and SLI (percent)

	Clinical method (IUD or *Norplant*)	Condom	Injectable	Oral pill	Female condom and VFT
Gender					
Male	0.0	93.8	3.3	10.9	32.0
Female	100	6.3	96.7	89.1	68.0
Total	100	100	100	100	100
Location					
Urban	87.5	21.9	27.2	16.4	40.0
Rural	12.5	78.1	72.8	83.6	60.0
Total	100	100	100	100	100
Age					
15–24	18.8	18.8	25.0	29.1	32.0
25–34	18.8	50.0	55.4	58.2	60.0
35 plus	68.8	31.3	19.6	12.7	8.0
Total	100	100	100	100	100
Reported monthly income (in thousands)					
400 or less	18.8	37.0	46.2	44.4	29.2
401–1,000	25.0	47.2	34.1	31.5	50.0
More than 1,000	56.3	15.7	19.8	24.1	20.8
Total	100	100	100	100	100
Education					
No school or primary only	56.3	28.1	54.3	61.8	36.0
Some or completed junior secondary	12.5	23.4	23.9	20.0	20.0
Some or completed secondary	18.8	26.6	14.1	9.1	28.0
Post-secondary education	12.5	21.9	7.6	9.1	16.0
Total	100	100	100	100	100
Asset-based SLI (standardized compared to entire population of Ghana)					
Highest 20%	12.5	15.6	31.5	27.3	24.0
Upper-Middle 20%	6.3	45.3	37.0	40.0	24.0
Lowest 60%	81.3	39.1	31.5	32.7	52.0
Total	100	100	100	100	100
Number of observations	**16**	**128**	**92**	**55**	**25**

is greater at clinics and hospitals than at pharmacies and chemical shops.

Table 14 shows data on the expressed willingness to pay for condoms by whether the customer received a consultation or examination. The customers who received a consultation or examination were slightly more willing to pay twice as much (65.4 percent versus 54.9 percent) than those who did not. This appears to confirm the observation that purchasers of family planning methods who receive consultations or examinations are more likely to be willing to pay double the current cost of the method.

Table 15 presents a tabulation of the condom results by condom brand. The willingness to pay more for *Panther* is greater than it is for *Champion*. Unfortunately, there were not enough *Protector* customers to include them in this tabulation. The most commonly sold brand of condom is "Other brand," which most likely comprises unbranded condoms distributed through public channels. Almost all of these condom purchasers are willing to pay at least 25 percent more than they are currently paying, and more than half are willing to pay double the current price.

Table 13. Willingness to pay more for methods obtained from MOH and PPAG facilities (percent)

	Clinical method (IUD or *Norplant*)	Condom	Injectable	Oral pill	Female condom and VFT
Not willing to pay more	0	6.3	4.3	3.6	8
Willing to pay 25% more	100	93.7	95.7	96.4	92
Willing to pay 50% more	100	85.1	84.8	92.8	88
Willing to pay 100% more	68.7	57	73.9	76.4	80
Number of observations*	**16**	**128**	**92**	**55**	**25**

* *Tabulations include both resupply and service/consultation clients.*

Table 14. Willingness to pay more for condoms obtained from MOH and PPAG facilities by receipt of consultation or services (percent)

	Condoms	
	Without consultation or services	With consultation or services
Not willing to pay more	6.9	3.8
Willing to pay 25% more	93.1	96.2
Willing to pay 50% more	83.3	92.3
Willing to pay 100% more	54.9	65.4
Number of observations	**102**	**26**

Table 15. Willingness to pay more for condoms obtained from MOH and PPAG facilities by brand of condom (percent)

	Champion	*Panther*	Other brand
Not willing to pay more	8.9	8	3.6
Willing to pay 25% more	91.1	92	96.4
Willing to pay 50% more	75.6	92	89.2
Willing to pay 100% more	46.7	72	57.1
Number of observations	**45**	**25**	**56**

5 What Will Family Planning Clients Do If the Price Increases Too Much?

WHAT WILL FAMILY PLANNING CLIENTS DO IF THE PRICE INCREASES TOO MUCH?

What will family planning clients do if the price increase for their product or service is more than they are willing to pay? Three possibilities exist, with some variation. First, the client could stop using family planning. Second, the client could find a cheaper brand or service delivery point for the method she or he is currently using. Or third, she or he could switch methods.

Table 16 (pharmacy and chemical shop clients) and Table 17 (MOH/PPAG clinics and hospitals) present tabulations of what clients say they would do if the price of their method increased too much. Fewer than 7 percent of clients for each purchase point say they would stop using contraceptives altogether. More than 50 percent of clients at both types of establishments would seek out cheaper alternatives to their current brand, either by seeking a cheaper brand at the same source or by seeking a cheaper source for the same brand. Almost one-quarter would switch to another method.

These results are also analyzed by the clients' expressed willingness to pay. The MOH/PPAG clients who are not willing to pay more are more likely to abandon family planning if the price goes up too much. However, relatively few clients are unwilling to pay anything more than they are currently paying.

What would people do if the price of their contraceptive method increased by 50 percent? Table 18 aggregates information from the previous sections and Table 16 to summarize clients' likely reactions. Here we see that across all methods obtained by clients of pharmacies and chemical shops, about 80 percent of clients would continue to purchase the same method at the same source. None of the injectable purchasers would stop purchasing family planning products. Fewer than 4 percent of the purchasers of condoms and 7 percent of purchasers of female condoms and VFT would stop purchasing their current family planning method.

Table 19 shows that more than 84 percent of all MOH/PPAG clients would continue to use the same method at the same source if prices increased by 50 percent. Fewer than 5 percent would stop using contraceptives.

To summarize, from a public health standpoint, marketers and policymakers should have little fear from increasing prices for family planning services and supplies when the price increases are moderate. These data indicate that purchasers of family planning have a strong inclination to continue using family planning. A price increase beyond what they are willing to pay will not cause wholesale abandonment of family planning, but may cause some adjustment of purchasing habits to a cheaper alternative.

Table 16. What will family planning clients do if the price increases too much: pharmacy and chemical shop clients (percent)

	Unwilling to pay more	Willing to pay 25% more	Willing to pay 50% more	Willing to pay 100% more	All men and women in sample
Sampled men and women	10.9	8.7	25.9	54.5	100
Stop using contraceptives altogether	15.3	7.9	8.7	4.1	6.9
Try to find a cheaper brand at this establishment	37.6	31.0	33.4	23.6	28.3
Try to find a cheaper source for the same brand	23.1	23.6	22.7	35.1	29.6
Switch to a different contraceptive method	18.4	29.6	27.8	21.6	23.6
All other responses	5.5	7.9	7.2	15.6	11.7
Total	100	100	100	100	100
Number of observations	**255**	**203**	**607**	**1,278**	**2,343***

* *The total sample size was 2,349; the responses from 6 survey participants were incomplete and, therefore, not included in the table.*

Table 17. What will family planning clients do if the price increases too much: MOH and PPAG clinic and hospital clients (percent)

	Unwilling to pay more	Willing to pay 25% more	Willing to pay 50% more	Willing to pay 100% more	All men and women in sample
Sampled men and women	5.0	7.5	20.6	67.0	100
Stop using contraceptives altogether	37.5	0.0	7.6	4.7	6.5
Try to find a cheaper brand at this establishment	18.8	25.0	30.3	20.9	23.1
Try to find a cheaper source for the same brand	12.5	25.0	24.2	31.6	28.7
Switch to a different contraceptive method	31.3	45.8	27.3	19.5	23.7
All other responses	0.0	4.2	10.6	23.4	18.0
Total	100	100	100	100	100
Number of observations	**16**	**24**	**66**	**215**	**321**

Table 18. What will family planning clients do if the price increases by 50 percent: pharmacy and chemical shop clients (percent)

	Condom	Injectable	Oral pill	Female condom and VFT
Keep on using same method at same source	80.3	82.9	81.4	79.8
Find a cheaper brand at this establishment	8.3	5.7	3.8	4.7
Find a cheaper source for the same brand	3.8	5.7	6.4	5.0
Switch method	3.8	2.9	5.7	6.7
Stop using contraceptives altogether	2.3	0.0	2.2	3.0
Other	0.2	0.0	0.0	0.0
Don't know	1.3	2.9	0.5	0.7
Number of observations	**1,462**	**35**	**547**	**298**

Table 19. What will family planning clients do if the price increases by 50 percent: MOH and PPAG clinic and hospital clients (percent)

	Clinical method (IUD or *Norplant*)	Condom	Injectable	Oral pill	Female condom and VFT
Keep on using same method at same source	100	85.2	84.8	92.7	88.0
Use a cheaper brand at this establishment	—	4.7	2.2	1.8	—
Find a cheaper source for the same brand	—	0.8	5.4	—	8.0
Switch method	—	7.0	5.4	3.6	—
Stop using contraceptives altogether	—	1.6	2.2	1.8	4.0
Don't know	—	0.8	—	—	—
Number of observations	**16**	**128**	**92**	**55**	**25**

6 Summary and Conclusion

SUMMARY AND CONCLUSION

There is considerable potential for increasing prices to improve the sustainability of subsidized family planning products and services, including condoms, in Ghana. For almost all products, more than 75 percent of clients say they are willing to pay at least 50 percent more than they are currently paying.

Purchasers of lower-priced condoms (*Champion* and *Panther*) seem to be more willing to pay higher prices for their products than purchasers of the higher-priced *Protector* condom. For purchasers of *Champion* and *Panther* condoms, willingness to pay more holds more or less constant across all SLI groups. Results from both the pharmacy/chemical shop and the MOH/PPAG clinic/hospital surveys indicate that the *Champion* condom has the greatest potential for a relatively large price increase.

For *Secure* oral contraceptives, wealthier purchasers are willing to pay more for the product. Even in the less-wealthy groups, more than 75 percent of clients are willing to pay an increase of 25 percent more.

More than 80 percent of *Famplan* injectable purchasers are willing to pay a price increase of 50 percent more. It is difficult to know, however, what the impact of a price increase would be on *Famplan* users because virtually none of the purchasers came from poorer groups.

More than 80 percent of the *Kamal* female condom purchasers are willing to pay a price increase of 50 percent more. However, implementers of any potential price increase should be aware that the results indicate that the *Kamal* purchasers who would cease to buy the product as a result of a price increase would be disproportionately poor. Among poorer female condom purchasers, almost 25 percent said they are unwilling to pay any price increase.

Among the clients of MOH and PPAG hospitals and clinics, there is near universal willingness to pay more than the current level of prices paid. An overwhelming majority of those surveyed are willing to pay either 50 percent or 100 percent more than the current price paid. The willingness to pay more was particularly high for the methods that require relatively intensive medical intervention, such as IUDs, implants, and injectables. Condom users who had received a consultation or an examination also expressed a greater willingness to pay more.

Finally, the question was addressed of what would happen if prices increased beyond what family planning clients are willing to pay. The results indicate that fewer than 10 percent of current family planning clients would stop using family planning. The majority said they would seek a cheaper brand at their current source of supply or try to find a cheaper source of supply for the same brand.

In summary, there is adequate room for marketers and policymakers to increase prices for all classes of family planning products in Ghana. Furthermore, within reasonable bounds, there is room for relatively aggressive price increases, since most family planning users are prepared to continue to use family planning even if their current brand becomes too expensive.

Appendix

APPENDIX

The total sample size for the study was 2,670 (2,349 for products and 321 for services). This sample was intercepted at the various facilities, based on usage and readiness-to-be-interviewed criteria.

Respondents were intercepted at the product/service delivery points after using/buying any of the products/services under consideration. This granted the opportunity to solicit relevant views and opinions from the right people since family planning products/services are not a day-to-day product/service with wide patronage.

Rural and urban centers were included for all of the 10 regions surveyed, given the assumption that income and expenditure levels vary, depending on the regions and the level of urbanity. This was relevant because the effect of a price increase on consumers' incomes varies, depending on levels of exposure and disposable income. This sampling strategy granted us the opportunity to solicit the views of people from all socioeconomic levels.

Table A1 shows the planned distribution of outlets across the regions. Table A2 shows the actual distribution of outlets across the regions.

Tables A3 and A4 show the number of respondents intercepted at the various outlets across localities within the regions for both services and products. Table A5 replicates the survey questions.

Table A1. Planned distribution of sampled outlets

	GSMF International		MOH		PPAG	
	Pharmacies	**Chemical shops**	**Hospitals**	**Clinics**	**Clinics**	**Total**
Ashanti	1	14	1	1	1	18
Eastern	1	12	1	1	1	16
Central	10	12	1	1	1	25
Brong Ahafo	1	10	1	3	1	16
Greater Accra	1	16	1	1	1	20
Northern	4	17	1	2	1	25
Western	1	14	1	2	1	19
Volta	1	7	1	1	1	11
Upper East	1	3	1	1	—	6
Upper West	1	3	1	1	—	6
Total	**22**	**108**	**10**	**14**	**8**	**162**

Table A2. Actual distribution of sampled outlets

	GSMF International		MOH		PPAG	
	Pharmacies	**Chemical shops**	**Hospitals**	**Clinics**	**Clinics**	**Total**
Ashanti	3	10	1	4	—	18
Eastern	1	5	—	—	1	7
Central	10	15	1	—	—	26
Brong Ahafo	3	6	—	2	1	12
Greater Accra	2	17	—	—	2	21
Northern	3	25	2	—	—	30
Western	—	12	—	2	—	14
Volta	1	6	—	1	—	8
Upper East	—	6	1	—	—	7
Upper West	—	3	—	1	—	4
Total	**23**	**105**	**5**	**10**	**4**	**147**

Table A3. Actual distribution of clinic and hospital clients by locality

	Urban			Rural		
	MOH clinics	**MOH hospitals**	**PPAG clinics**	**MOH clinics**	**MOH hospitals**	**PPAG clinics**
Ashanti	—	—	—	6	21	—
Eastern	—	—	25	1	—	25
Central	—	—	—	—	—	8
Brong Ahafo	—	—	—	49	—	—
Greater Accra	13	—	—	—	—	—
Northern	—	—	—	35	—	—
Western	23	—	—	33	17	—
Volta	—	—	—	10	2	3
Upper East	2	23	—	—	—	—
Upper West	—	—	—	25	—	—
Total	**38**	**23**	**25**	**159**	**40**	**36**

Table A4. Actual distribution of pharmacy and chemical shop clients by locality

	Urban		Rural	
	Pharmacies	**Chemical shops**	**Pharmacies**	**Chemical shops**
Ashanti	81	192	3	155
Eastern	43	159	17	177
Central	1	33	1	69
Brong Ahafo	2	103	3	181
Greater Accra	266	270	1	4
Northern	17	93	1	51
Western	45	18	3	111
Volta	19	67	1	77
Upper East	—	41	—	1
Upper West	—	41	—	2
Total	**474**	**1,017**	**30**	**828**

Table A5. Price guides for willingness-to-pay questions

INTERVIEWER: Find the TOTAL price that the family planning client says that he/she paid [Q 310] among the ranges listed in the first column. Transcribe the prices in following three columns into the appropriate blanks for questions 402, 403, and 404.

Price paid for family planning (cedis)

	Question 402	Question 403	Question 404	Question		Response code (write in or circle code)
IF QUESTION 304	**INC 1**	**INC 2**	**INC 3**			
0 to 100	150	200	125	**401**	**IUD insertion**	01
					IUD removal	02
101 to 200	300	400	250		***Norplant* insertion**	03
					***Norplant* removal**	04
201 to 300	450	600	375		**Sterilization**	05
					Emergency contraceptive pill	06
301 to 400	600	800	500		***Champion* condom**	11
					***Panther* condom**	12
401 to 500	750	1,000	625		***Protector***	13
					Conceptrol	14
501 to 1,000	1,500	2,000	1,250		***Famplan***	15
					IUD	16
1,001 to 1,500	2,250	3,000	1,875		***Kamal***	17
					Secure	18
1,501 to 2,000	3,000	4,000	2,500		**Female condom**	19
					Injectables	20
2,001 to 2,500	3,750	5,000	3,125		**Male condom**	21
					Neo-sampoon/jelly/cream (tube)	22
					Oral pill	23
2,501 to 3,000	4,500	6,000	3,750	**402**	**You said you paid [quote total price respondent paid] for today's service(s).**	
3,001 to 3,500	5,250	7,000	4,375			
3,501 to 4,000	6,000	8,000	5,000		**If the price increased to [INCREMENT 1], would you continue to use the service/products?**	YES 1 (ask question 403)
4,001 to 4,501	6,750	9,000	5,625			NO 2 (skip to 404)
4,501 to 5,000	7,500	10,000	6,250			
5,001 to 7,500	11,250	15,000	9,375			
7,501 to 10,000	15,000	20,000	12,500			
10,001 to 15,000	22,500	30,000	18,750	**403**	**If the price increased to [INCREMENT 2], would you continue to use the service/products?**	YES 1 (go to 405)
15,001 to 20,000	30,000	40,000	25,000			NO 2 (go to 406)
20,001 to 30,000	45,000	60,000	37,500			
30,001 to 40,000	60,000	80,000	50,000			
40,001 to 50,000	75,000	100,000	62,500			
50,001 to 100,000	150,000	200,000	125,000			
100,001 to 200,000	300,000	400,000	250,000			
200,001 to 300,000	450,000	600,000	375,000	**404**	**If the price increased to [INCREMENT 3], would you continue to use the service/products?**	YES 1 (go to 406)
300,001 to 400,000	600,000	800,000	500,000			NO 2 (go to 406)
400,001 to 500,000	750,000	1,000,000	625,000			

Table A5. continued

	Question	Response code (write in or circle code)		Skip
405	**What is the most you would pay for [family planning product] at this establishment?**			
		Amount	_____	
		Don't know	999998	
		Refused	999999	
406	**If the price of [family planning product] at this establishment went up more than you were willing to pay, what would you do instead?**			
	CIRCLE ONLY ONE RESPONSE	Try to find a cheaper brand at this establishment	1	
		Try to find a cheaper source for the same brand	2	
		Switch to a different contraceptive method	3	
		Stop contraception altogether	4	
		Other (specify)	_____	
		Don't know	98	
		Refused	99	

COMMERCIAL MARKET STRATEGIES
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

USAID FUNDED BY:
United States Agency for International Development
USAID Contract No. HRN-C-00-98-00039-00

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